# EXHIBIT L

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

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| IN RE: ETHICON, INC., PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION | :Master File No. :2:12-MD-02327 : |
| THIS DOCUMENT RELATES TO THE FOLLOWING CASES IN WAVE 2 OF MDL 200: | : : |
| PATRICIA MARTIN AND DENNIS MARTIN, SR., Plaintiffs, | :JOSEPH R. GOODWIN :U.S. DISTRICT JUDGE |
| v. ETHICON, INC., et al., Defendants. | : :Case No. :2:12-CV-02185 |

June 6, 2016

Videotaped deposition of KONSTANTIN WALMSLEY, M.D., held at COURTYARD MARRIOTT WEST ORANGE, 8 Rooney Circle, West Orange, New Jersey, before Margaret M. Reihl, RPR, CCR, CRR, CLR and Notary Public, on the above date, commencing at 9:04 a.m.

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I N D E X



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E X H I B I T S



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... KONSTANTIN WALMSLEY, M.D., having been duly sworn as a witness, was examined and testified as follows ...

BY MR. GRIFFIN:

Q. Doctor, for my name is Will Griffin, and I represent Johnson & Johnson in a lawsuit regarding Pamela Martin, and is it my understanding that you've been retained as an expert for the plaintiffs in this matter in that case?

A. Yes, sir.

Q. Could you state your full name.

A. Konstantin Walmsley.

Q. And your address?

A. 282 Forest Avenue, Glen Ridge, New Jersey 07028.

Q. And can you tell me in the Pamela Martin case what you've reviewed?

A. Yes, sir. It's enclosed in my report. There are a variety of different medical records listed in the report, including Siloam Springs Regional Hospital, that's S-i-l-o-a-m, St. John Medical Center, Mercy Hospital Northwest Arkansas, International Urogynecology Associates.

Q. And I don't think you need to go through

all of those, but were there any medical records beyond the ones that are listed here?

A. No, sir.

Q. Were there any depositions you reviewed in this case?

A. That's correct.

Q. There were?

A. Yes.

Q. What depositions?

A. The deposition I believe of the implanting surgeon and of the patient.

Q. Anything else that you reviewed?

A. No, sir.

MR. GRIFFIN: Okay. Let's mark this as exhibit.

(Document marked for identification as Walmsley-Martin Deposition Exhibit No. 1.)

BY MR. GRIFFIN:

Q. What I've marked as Exhibit 1, is that a copy of your opinions in this case?

A. Yes, sir.

Q. And with the addition of the two depositions that you said, does that cover all of the documents you've reviewed in relation to this

particular case, the Martin case?

A. Yes.

MR. GRIFFIN: Introduce that as Exhibit 1.

BY MR. GRIFFIN:

Q. Dr. Walmsley, how often have you testified?

A. I have testified probably between 10 and 20 times.

Q. Is that all by deposition or sometimes at trial?

A. There have been -- mostly deposition and a few trial appearances.

Q. Okay. Other than -- have they all been in mesh cases?

A. No, sir.

Q. Some medical malpractice cases?

A. Yes, sir.

Q. How many were medical malpractice cases?

A. Perhaps five to six.

Q. And that would leave the other 15, 10 to 15 being mesh cases?

A. Yes, although that 10 to 15 might be a bit of a generous estimate, in retrospect.

Q. And what companies have you testified against in mesh related litigation?
A. Today's obviously, Bard, Boston Scientific.
Q. And about how much have you made from testifying in mesh cases and reviewing cases related to mesh?
A. I probably received on the order of 40 to $50,000.
Q. Have you implanted TVT devices?
A. I have.
Q. Have you implanted TVT-O devices?
A. I have not.
Q. Have you had any training in the implantation of TVT-O devices?
A. Yes, sir.
Q. Where did you obtain that training?
A. In my fellowship and in a workshop soon after I finished my fellowship.
Q. Beyond -- was that a cadaver workshop?
A. Yes, sir.
Q. Beyond doing it on a cadaver, have you ever done a TVT-O on a human, a live human?
A. No, no, I've never done one primarily

myself.

Q. About how many midurethral mesh slings have you implanted?

A. Over my career, probably between about three and 500.

Q. Have you implanted mesh midurethral slings this year?

A. I have.

Q. How many have you implanted this year?

A. Estimate about four or five.

Q. Have you taken part in or published any studies related to stress urinary incontinence?

A. I have not.

Q. Doctor, if you have your report in front of you, as I understand it, Ms. Martin has had two procedures by Dr. Hill.

Is that your understanding?

A. It is.

Q. July 17th, 2009 was a TVT procedure -- 12, 2009; is that correct?

A. Yeah, June 12th, 2009, yes, sir.

Q. And on April 16, 2010 he did -- I always mess up this word -- pronounce it for me, please.

A. Yes, sir, it's a posterior colporrhaphy.

Q. Colporrhaphy, thank you.

In your -- between the time of the TVT operation on July 12, 2009 and the colporrhaphy on April 16, 2010, did the plaintiff, Ms. Martin, ever complain of dyspareunia?

A. I think you meant June 12th, 2009, correct?

Q. Yes. What did I say?

A. I thought you said July 12th.

Q. Okay, you're right.

A. No, not from my review of the medical records did I see that.

Q. Okay. When was the first time she complained of dyspareunia?

A. July 11th, 2011 is my first memorialization of that, reviewing her medical records.

Q. And what did she relate that to?

A. Well, she related it to pain with intercourse.

Q. But when did she say it started?

A. I mean, from what I recall reviewing the medical records, it started somewhat recently prior to that visit.

Q. Did she, in fact, state that she was

complaining -- she complained of dyspareunia which was present almost constantly since her posterior colporrhaphy?

A. Interestingly, my recollection of that, and this is based on her September 29th visit, is that she had had this present since her TVT-O and posterior colporrhaphy, so I don't recall that specific element.

Q. I'm going to show you the Martin record, Martin and it's MDR0024.

A. Thank you.

Q. Do you remember reviewing that?

A. I did see this letter, yes.

Q. Okay. In that letter dated July 19, 2011, what is the time frame from which Ms. Martin dates her dyspareunia?

A. Well, this -- I mean, to be fair, this is Dr. Hill's letter to Dr. Lewis in which he is stating, and I quote, "she is complaining of dyspareunia which she states has been present almost constantly since her posterior colporrhaphy."

Q. Okay. And in your report, you did not -- let me see your report, in bullet point at the bottom of the page, that is not contained, is it, that it's --

A. Only insofar as I tend to rely upon the actual medical record and office visit material to some degree more than a letter to a colleague, I did not.

Q. Okay. MDR0004 of the Martin, Chad Hill records from Siloam Springs.

A. This is July 19, 2011. I see this, yeah.

Q. And what does that indicate to you?

A. That indicates patient complains of dyspareunia since posterior colporrhaphy and severe menopausal symptoms.

Q. So two years after her TVT procedure, she was relating her dyspareunia to her posterior procedure; is that correct?

A. In the July 11th note, that is correct.

Q. Did Dr. Hill examine her at that time, according to your review of the deposition and your review of the medical records?

A. Yes.

Q. Did he palpate the site of his posterior procedure?

A. Yes.

Q. And is that where she claimed discomfort?

A. I don't quite recall.
Q. Did you read Chad Hill's deposition?
A. I did.
Q. And did Chad Hill indicate that there was no pain upon insertion at that time?
A. As I recall, that's what was stated in the deposition.
Q. And the area that he found tenderness was where the rectocele repair was done, that being the second procedure that he did, correct?
A. Well, that's somewhat in conflict to your original question. Could we repeat the second to last question, just so I understand it.
Q. Okay. Dr. Hill palpated the area where he had done the second procedure, correct?
A. Yes.
Q. And that's where she claimed that there was tenderness, correct?
A. In the July 11th visit, yes.
Q. Okay. Now, where is her pain now?
A. As of my most recent evaluation of her, her pain is in the anterior vaginal wall.
Q. Is that different than what she was complaining to Dr. Hill about?

A. Only on July 11th, this is true, yes.
Q. In any of Dr. Hill's records or during his deposition, was there ever complaints in the anterior compartment?
A. Yes, sir.
Q. And when was that?
A. September 29th, 2011.
Q. And in his report did he indicate she had pain in the anterior compartment at that time?
A. As I recall the medical record documents, complaints of severe anterior vaginal dyspareunia that had been present since her TVT-O and posterior colporrhaphy surgery.
Q. And did he examine her at that time?
A. I don't recall. If there was an examination, I don't -- obviously didn't include it in my report, so I don't know if it was necessarily contributory to her complaint.
Q. Where did you locate the pain?
A. When I examined her, she did have pain in the anterior vaginal wall.
Q. Where on the anterior vaginal wall?
A. Show you here. Just going to find my examination documentation in my report. It was

reproducible on the left vaginal sulcus in the area where her sling was excised and partially removed. That's under Opinion 5.

Q. And I'm looking at your actual notes from your examination.

So it's the left vaginal sulcus, and when you say that, do you mean below the urethra or toward the bottom of the vaginal vault?

A. If you can imagine the vaginal space, it would be probably along the location of the mid urethra in the typical location of where a transobturator sling is seated underneath the urethra.

Q. So are you -- if we use the face of a clock, are you talking about 12:00?

A. I'm talking about probably 1:30 to 2:00, yes, sir.

Q. Okay. And how far in?

A. Probably in the expected location if you were to draw an imaginary line from the mid urethra towards the obturator canal, probably right along that trajectory.

Q. Now, where did the patient describe pain to Dr. Miklos?

A. The vaginal opening.

Q. Was that a different location than where you had found it?

A. Not necessarily. If I may, he documented that she had no vulvar pain, that the pain was at the vaginal opening and with intercourse at entry.

And if you imagine the location of the urethral opening, which can be variable in certain patients, but in Ms. Martin's instance is essentially at the level of the vaginal introitus, 1 centimeter is not very far in, if you will.

Q. Okay. Your examination found pain suburethral, correct?

A. Part of her location of her pain was suburethral, that's correct.

Q. And he found pain where exactly?

A. He described pain at entry and pain at the vaginal opening.

Q. Did he actually look for pain suburethral?

A. Well, I imagine it may be semantics, but suburethral and vaginal opening in a sense can be synonymous, simply because if one is putting one's examining finger into the vaginal space, you're

immediately suburethral upon entry, particularly if you're palpating anteriorly on the upper part of the vaginal space.

Q. And you're saying "upper," you're saying on the -- you said 1:30 position is where you palpated and found tenderness?

A. That was where the vaginal sulcus on the left side is, yeah.

Q. So that would be periurethral bilateral, but one-sided?

A. One side greater than the other.

Q. Okay. So you would be looking for pain periurethral on the left side to match what you found, correct?

A. That's where the most sensitive area was on examination.

Q. Did you examine her -- the ring where her hymen would have been?

A. Yes, sir.

Q. And what did you find there, any pain there?

A. As I recall, there was -- and I'd have to look at my IME to get the verbiage correct, but the pain wasn't just in one particular area.

MR. GRIFFIN: Why don't we mark this Exhibit 2.

(Document marked for identification as Walmsley-Martin Deposition Exhibit No. 2.)

BY MR. GRIFFIN:

Q. I'm going to show you what's Exhibit 2. Is that the notes from your evaluation of Ms. Martin?

A. Yes, sir. Thank you.

Q. From that can you read to us where you identified the pain?

A. Yes. "On vaginal exam she had tenderness especially along the left vaginal sulcus were palpable scars appreciated."

Q. And that left vaginal sulcus would be suburethral or periurethral, correct?

A. That's correct, perhaps more periurethral in terms of the vaginal sulcus.

Q. Right. Did Dr. Miklos test that area?

A. I imagine he did, yes.

Q. Do you know what he found?

A. I'd have to look at the records to specifically tell, but my report states that he did suggest scar revision surgery and a laparoscopic Burch

procedure for her incontinence.

Q. What kind of scar revision surgery was he going to do?

A. He had intended on performing a vaginal and vulvar scar revision along with a perineoplasty, which describes work on the posterior vaginal space in anticipation of her moving additional scar material.

Q. Well, he recommended two things, did he not, a laparoscopic Burch and a perineoplasty?

A. That's correct, well actually three things, if you include the scar revision surgery.

Q. Where was the scar that he wanted to take care of, was it suburethral?

A. He described it as vaginal and vulvar, so, I mean, vaginal can certainly include the suburethral and/or periurethral area for that matter.

Q. Was it at the opening, or was it at the suburethral in the anterior compartment?

A. Well, I mean, I think, once again, those two terms are synonymous in terms of I guess my description or our description.

Q. Okay. Just so we're clear, he recommended two procedures, correct?

A. I would say three.

Q. Okay. I'm going to show you his medical record. This is MDR 30. These are Martin -- Patricia Martin's record, and this would be International Center for Laparoscopic Urogynecology.

A. Yes, sir.

Q. Do you remember reviewing the pictures?

A. Yes.

Q. Okay. And the first thing is incontinence, the diagnosis, and what does he recommend for that?

A. A laparoscopic Burch.

Q. And the second thing is a vaginal opening scar, that's the diagnosis. What does he recommend for that?

A. Perineoplasty.

Q. And that would be in the posterior compartment, correct?

A. Perineoplasty is in the posterior compartment, that's correct.

Q. That would not be the area where the mesh was, correct?

A. If that's what he was to do, yes.

Q. And that's what he, in fact, gave her on the recommendation sheet that's attached to his file,

isn't it, you reviewed that?

A. He suggested that, yes.

Q. Now, Dr. Miklos in his records did not suggest her dyspareunia was caused by the sling or by contraction of mesh, did he?

A. May I?

Q. Sure.

A. (Witness reviews records.)

May I hear the question back.

(The court reporter read back the record as requested.)

THE WITNESS: There's no comment in his medical records attributing dyspareunia to mesh.

BY MR. GRIFFIN:

Q. He also did not suggest removal of any mesh, did he?

A. With her having had mesh removal by Dr. Marinis, if I'm saying his name correctly, he did not.

Q. In fact, Dr. Miklos found no pain suburethral or periurethral, did he?

A. His examination note didn't indicate that.

Q. That's the area where you found pain, though, correct?

A. I found pain at -- and you and I have used these terms synonymously, the entry area and specifically on my exam in the anterior vaginal wall in the area of both sub and perivaginally, but, once again, suburethra and vaginal opening are synonymous.

Q. Well, Dr. Miklos found absolutely no pain suburethral or periurethral in his examination, true?

MR. THOMPSON: Object to the form.

THE WITNESS: His part of his medical record states that, yes.

BY MR. GRIFFIN:

Q. Okay. And suburethral and periurethral would be where the mesh was, correct?

A. Well, suburethral where the mesh was, periurethral where the mesh still is and was, because not all of the mesh was removed.

Q. Okay. But that -- whatever mesh would be suburethral or periurethral, correct?

A. Depending upon semantics, that's correct.

Q. Well, Dr. Miklos specifically found zero

out of five pain suburethral and periurethral, correct?

A. In part of his exam he documents that.

Q. And looking at your opinions in this matter, your Opinion Number 1, I think goes primarily to the IFU; does it not?

A. Yes, sir.

Q. And is it my understanding that if the IFU had included mesh contraction, mesh shrinkage, scar plate formation and dyspareunia, then the IFU would have been sufficient, in your mind?

MR. THOMPSON: Object to the form.

THE WITNESS: In part, yes.

BY MR. GRIFFIN:

Q. The second part of that goes to what Dr. Hill did or didn't know, what he had knowledge of, as I understand your Opinion Number 1; is that correct?

A. Yeah, based on the insufficiency of the IFU, yes.

Q. Okay. Did Dr. Hill read the IFU?

A. Not to my knowledge.

Q. So whatever was in the IFU, he would not have obtained from reading it, correct?

MR. THOMPSON: Object to the form.

THE WITNESS: Unless he had been briefed

on the IFU by someone with the company when training on this.

BY MR. GRIFFIN:

Q. And what knowledge did Dr. Hill have of the potential risk and complications of the TVT-O?

A. Well, based on the medical record, he did run through a couple of things.

Q. Did you review his deposition?

A. I did.

Q. In his deposition did he indicate that he was aware of the risk of mesh contraction, mesh shrinkage, dyspareunia, pelvic pain?

A. To some degree he stated that.

Q. Did he testify that he was aware of all of those things from his training, from discussions with colleagues and from reading the literature?

A. He made comments to that effect.

Q. Did he indicate that even if you had included all of these other complications in the IFU, it would not have changed his recommendation to use the TVT in this case?

A. I can't really lend any credence to that comment.

Q. Well, did you read his deposition where

he said that?

A. I did.

Q. Did Dr. Hill indicate that the IFU did not have anything to do with his recommendation or to use a TVT-O?

A. I don't recall the language used, but I do acknowledge that he didn't read the IFU.

Q. Did he -- whether or not all of the information you contend should be in the IFU, you do admit that Dr. Hill was aware of those risks according to his testimony?

MR. THOMPSON: Object to the form.

THE WITNESS: Well, I would argue no.

BY MR. GRIFFIN:

Q. Did he testify he was aware of them?

A. Based on his training and discussions with colleagues, he made comments to that effect.

Q. Okay. Well, a physician obtains information regarding the risks and complications of any particular procedure from a number of sources, don't they?

A. I think that's a fair comment.

Q. I mean, one of the sources is the IFU, correct?

A. Yes, sir.

Q. Another source would be the training that they get in a particular procedure, whether it's in their residency or after their residency and seminars, things of that sort?

A. I think that's a fair comment.

Q. It's also based upon their own experience; different physicians have different experiences, true?

A. I agree.

Q. And it's also based upon the literature that they might read or come in contact with, true?

A. I concur.

Q. And all of that information goes in to the physician's makeup, in essence, in order to give adequate informed consent to a patient, true?

A. I think that's true, but that depends upon, for example, if one's discussions with other colleagues, if one's training, if one's review of the literature has been influenced by an appropriate IFU.

Q. Well, did Dr. Hill agree that he was aware of all of the potential risks and complications which you indicate should be in the IFU based upon his training, experience and his discussions with

colleagues?

A. To the best of his knowledge.

Q. Your Opinion Number 2 is that, as I understand it, safer alternatives existed in 2009?

A. Yes, sir.

Q. But as of 2009 you were doing TVT-type procedures yourself, correct?

A. I was.

Q. And you were trying to provide the best care for your patients, true?

A. Yes, sir.

Q. And, as I understand it, you do not intend to give opinions as a design expert; is that correct?

A. No, I'm not planning on doing that.

Q. You indicate because of lack of information in the IFU, Dr. Hill could not warn Ms. Martin of the complications?

A. That's correct.

Q. At the time you wrote that in your report, you had not had an opportunity to review Dr. Hill's deposition; is that correct?

A. That's correct.

Q. Since you reviewed Dr. Hill's

deposition, do you agree that he did have the information available to warn Ms. Martin of complications?

A. I do not.

Q. And why do you say you do not, when he says he did have that information?

MR. THOMPSON: Object to the form.

THE WITNESS: Because my opinion is that the IFU, whether it's read by an implanting surgeon or not, is one of the important foundations to provide informed consent, and when anyone, myself or anyone else, decides to perform a procedure using a device, I personally rely upon the IFU, but in the absence of reading the IFU, I'm deriving information from key opinion leaders, my own experience, literature, and all that literature, to some degree, is founded on a thorough IFU.

For example, if Dr. Hill had asked one of his colleagues down the street, hey, you know, I want to implant this TVT-O, what do you know about it, and if the other implanting surgeon had actually read the IFU he might say,

well, you know, it definitely is easier than an autologous fascial sling; however, you know, there are some real potential risks to the mesh, and sometimes when these patients have dyspareunia, it's very difficult to treat. Might that have influenced or improved his fund of knowledge going into surgery? I believe it would.

BY MR. GRIFFIN:

Q. Did any of that occur or not occur, or do you know?

A. Well, based on his deposition and what you and I have discussed, it would seem that his fund of knowledge, which he claims is complete, I would argue is tainted by the fact that the IFU at that time was incomplete.

Q. Did he testify he was aware of the risk of acute and/or chronic pain with intercourse?

MR. THOMPSON: Object to the form.

THE WITNESS: As I recall, he did make that statement.

BY MR. GRIFFIN:

Q. Did he testify that he was aware that there was a risk of acute and/or chronic pain?

MR. THOMPSON: Object to the form.

BY MR. GRIFFIN:

Q. With the use of mesh or indeed with nonmesh procedures?

A. He did, although I don't recall the date of the deposition, but it was fairly recent, if my memory serves me.

Q. And did he indicate he was aware of all of these things before he ever performed a procedure on Ms. Martin?

A. As I recall, that comment was made.

Q. And he also testified that he was aware of the risk of infection, urinary problems, organ nerve damage, bleeding, wound complications, inflammation, fistula formation, neuromuscular problems, one or more revision surgeries to treat an adverse event, recurrence, failure, foreign body response, erosion, exposure, extrusion and contraction or shrinkage of tissues?

A. Sounds like you read part of the IFU, sorry, but he did make that comment, yes.

Q. He did agree that he knew all those risks and complications, correct?

A. He commented on that at his deposition,

yes.

Q. And he testified that he was aware of all that information before he made the implantation of the TVT-O device in Ms. Martin, correct?

MR. THOMPSON: Object to the form.

THE WITNESS: He made comments to that effect in his deposition, yes.

BY MR. GRIFFIN:

Q. In Opinion Number 3 you indicate that Ms. Martin suffered a vaginal sling contraction and scar plate formation as a result of the physical properties of the TVT device, true?

A. Yes, sir.

Q. And it's your opinion that the TVT contracted post implantation?

A. That's correct.

Q. And what do you base that on?

A. I base that on Dr. Marinis' operative dictation, the findings of the tape being tense or taut upon removal. I also base that on changes to the bladder which were seen at the time of sling removal.

Q. And I'm going to butcher this word, trabeculations?

A. Trabeculations being that finding, yes,

sir.

Q. And you indicated that this caused trabeculations that were not present on prior -- they were not present on prior cystoscopies, correct?

A. Yes, sir.

Q. Were they present on subsequent cystoscopies as well, the trabeculations?

A. I don't recall that terminology being used.

Q. Once they're there, they're going to stay there, though, right?

A. They tend to persist even beyond the removal of the offending cause, if you will.

Q. So subsequent cystoscopies should turn that up if we look for them, correct?

A. Theoretically, they should show some degree of trabeculations, yes, sir.

Q. Right. And the other reason you indicated that it appeared that the mesh was -- the mesh had contracted was because her inability to void completely, I guess would be the proper word, started at some point subsequent to the surgery, it was gradual?

A. That symptom development, yes, started

gradually after that surgery.

Q. Did she, in fact, have that symptom before she ever had the surgery?

A. When you say that surgery, you're referring to the TVT-O surgery?

Q. Yes.

A. I have to see the historical records to confirm that.

Q. Well, you read her deposition, didn't you?

A. I did.

Q. And in her deposition did she not indicate that she had problems emptying her bladder before she ever had a TVT-O procedure?

A. I recall seeing that, although I don't see anything in the medical records that speak to that.

Q. But we do have her sworn testimony that she had problems emptying her bladder. When she would go to the restroom, she would feel like there was still urine left that she couldn't empty, true?

A. Yes.

Q. So one of the basis for your opinion that it contracted was the fact that she had developed this inability to empty her bladder completely,

correct?

A. To some degree, yeah.

Q. And, in fact, she had those symptoms, according to her testimony, before she ever had the TVT-O procedure true?

A. I'm not sure to the same severity with which she developed them following, but her deposition would say that, would indicate that.

Q. To be fair, you weren't there to assess her before or after, correct?

A. This is true.

Q. All we have is her testimony as to when this problem began, correct?

A. Yes.

Q. And this problem with emptying her bladder began before the TVT procedure was ever performed, according to her testimony, correct?

MR. THOMPSON: Object to the form.

THE WITNESS: In her deposition she made comments to that effect, yes.

BY MR. GRIFFIN:

Q. And your next opinion is Opinion 4. And do I understand Opinion 4 correctly that you have outlined the causes of dyspareunia and ruled in or

ruled out certain potential causes?

A. Yes.

Q. So you ruled out vestibulitis because it was not documented in the medical record anywhere, correct?

A. There's a question of vestibulitis, I believe, in Dr. Marinis' records that are more or less ruled out, as I recall.

Q. Okay. So as I understand it, you ruled out vestibulitis as a potential causes for dyspareunia because it was not documented in the medical records, correct?

A. Not precisely.

Q. Okay.

A. There was a question raised as to vestibulitis in the records of Dr. Marinis; however, the treatment that would have otherwise resolved that condition were completely ineffective.

Q. Well, is your point vestibulitis was never definitively diagnosed by anybody in the medical records, and that's why you ruled it out?

A. That's correct.

Q. And if it is documented by the treating physicians, you wouldn't rule it out, correct?

A. If it was documented and found to be true, based on subsequent records and evaluation, I would not.

Q. You would not rule it out, true?

A. That's correct.

Q. Okay. Did you rule out pain in the area of the colporrhaphy?

A. I did.

Q. And that's because it's not documented in the records, correct?

A. No, that's because my independent medical exam indicated no pain to palpation in the area of the posterior colporrhaphy, nor did her subjective pain exist in that area.

Q. You ruled out vaginal tissue atrophy because it was not mentioned in the records, correct?

A. That's not precisely true either.

Q. You found it, I understand that, in 2016 but --

A. That was the point I wanted to make.

Q. Okay. But your point is in the 2011, '12 period, there was no mention of vaginal tissue atrophy, correct?

A. That was part of -- yeah, part of my

conclusion was based on that finding, yes.

Q. And so one way to determine whether the patient has vaginal tissue atrophy and that's causing dyspareunia is to use the hormonal creams, correct?

A. That's one of the treatments of vaginal tissue atrophy.

Q. And if the patient notes improvement upon using the cream, that gives you some indication that her dyspareunia may be caused by the lack of estrogenization or the vaginal tissue atrophy, correct?

A. Can be a contributing factor.

Q. And the reason you ruled that out was because that was not documented in the medical records either, true?

A. Part of the reason, yes.

Q. Any other reason you ruled it out?

A. Yes, sir.

Q. What?

A. Well, specifically for a good period of time, she was on oral hormonal replacement therapy, number one. And subsequent to the discontinuation of the Cenestin, which is C-e-n-e-s-t-i-n, she was more or less on topical hormonal therapy throughout her treatments.

Q. Did she ever note improvement with the topical hormone?

A. As I recall, she may have, but I don't specifically recall there.

Q. You don't recall one way or the other?

A. Only insofar as in formulating this opinion based on -- certainly, based on the medical record review and my independent medical examination, whereas vulva vaginal atrophy essentially creates a somewhat diffuse dyspareunia, her dyspareunia was fairly site specific.

Q. Well, hers was to the point. She said her husband could not enter her, correct?

A. At times, yes.

Q. Did you rule out that the patient may need a vestibulectomy?

A. I did rule that out.

Q. And is that because it was not stated in the medical records?

A. In part, yes.

Q. And the other thing you excluded was pelvic floor dysfunction because of absence of tenderness to the pelvic floor musculature, correct?

A. During my examination, yes, and that of

Dr. Miklos as well.

Q. And you ruled out pudendal neuropathy, true?

A. I did, yes.

Q. And how did you rule that out?

A. Based on several factors, one being, of course, my independent medical examination, both clinically and examination-wise, and then on the basis of the lack of documentation on Dr. Miklos' part and, thirdly, more or less on the basis of Dr. Marinis entertaining this concept yet seeing no resolution with the typical treatments used to treat pudendal neuropathy.

Q. So if we wanted to rule back in vestibulitis, we would have to find that in the medical records, that some physician had diagnosed that, correct?

A. I think to some degree it depends on the chronology and timing of that diagnosis, number one, and, number two, whether or not the traditional therapies for that have led to relief of symptoms.

Q. Well, one of the therapies, of course, is going to be a vestibulectomy, correct?

A. For vestibulitis you mean?

Q. Yes, yes.
A. Yes.
Q. I'm going to show you the records from Premier Care for Women. This is dated 4/19/2012, and there was an examination done by Dr. Peacock at that time, and this is Premier Care for Women, MDR 16.
What does she diagnose at that time regarding vestibulitis?
Did you find that, Doctor?
A. There's a comment in there regarding vestibulitis present.
Q. And this physician on April 19, 2012 diagnosed vestibulitis in this particular patient, Ms. Martin, correct?
A. Yes.
Q. And, in fact, Dr. Peacock discussed with the patient a vestibulectomy, correct?
A. In part.
Q. Dr. Peacock also discussed with the patient that her dyspareunia may have been the vestibulodynia and unrelated to the sling, true?
A. As part of her discussion, she mentions that.
Q. She also discussed the area in the upper

posterior vagina that may require physical therapy, correct?

A. Can you repeat the question again. I'm sorry.

Q. She also discussed with the patient that the upper posterior area of the vagina may require physical therapy, massage therapy to relieve, true?

A. That's what's stated there, yes.

Q. And that area would not be where the mesh is, true?

A. That area is not where mesh is located.

Q. And the vestibulitis, that is not caused by mesh, true?

A. Possibly. It's unclear to me.

Q. There's no study that suggests that, correct?

A. Well, there's also no study that I know of that correlates pudendal neuropathy to mesh, and Dr. Marinis makes that claim in his assessment too.

Q. But there's no study that you've read that links vestibulitis with mesh, correct?

A. Not that I'm aware of.

Q. Okay. So you have no scientific evidence that would suggest that vestibulitis is caused

by the implantation of mesh, correct?

MR. THOMPSON: Object to form.

THE WITNESS: Not directly.

BY MR. GRIFFIN:

Q. So potentially we can rule the vestibulitis back into the picture, correct, for a potential cause of the dyspareunia, correct?

A. Perhaps in 2012, that would be in the differential.

Q. One of the other -- we talked about vaginal tissue atrophy. That is one of the things that Dr. Peacock found in April of 2012, correct?

A. I'm sorry. Where do you see that?

Q. Maybe I can help you, Page 19.

A. I don't have Page 19 here. I'm sorry.

Q. It's probably not in order. It's after this picture.

A. Oh, I see that now.

Q. There's a history and physical.

A. Yes, yes, you're talking about from May 17th, 2012, correct?

Q. Right.

A. That's interesting.

Q. And on that history and physical, what

happened when the patient started using Estrace and Vagifem?

A. Discussed modest improvements, that's what's stated in the plan.

Q. Okay. Under the history of present illness on Page 19, do you have that, Page 19?

A. I see that, yes.

Q. 5/17/12, has been using Estrace and Vagifem, still with some dyspareunia but husband can now enter her.

A. I see that.

Q. Do you see that?

And Estrace and Vagifem would be estrogen creams, correct?

A. That's correct.

Q. And then if you go to Page 20 under the examination of the external genitalia.

A. Yes.

Q. It indicates vestibulitis present and the atrophy was improving.

A. I see that.

Q. That would indicate that some of her dyspareunia at least may well have been caused by the fact she was not adequately estrogenized or she had

vaginal atrophy, correct?

MR. THOMPSON: Object to the form.

THE WITNESS: In 2012 I would concur.

BY MR. GRIFFIN:

Q. And she, in fact, had vaginal tissue atrophy when you examined her in 2016, correct?

A. I described it as mild as I recall, but, yes, nontender to vulvar palpation, as I documented.

Q. So vaginal tissue atrophy is something we can rule back in now that we've looked at the medical records, correct, as a cause of dyspareunia, true?

A. I would disagree with that.

Q. Well, at least as of 2012, we can rule it back in, correct?

A. I think based on Dr. Peacock's assessment, there's truth to that, yes.

Q. So as of 2012 when Dr. Peacock was examining the patient, we can rule back in vaginal tissue atrophy as a potential cause of her dyspareunia?

A. I wouldn't necessarily agree with that, although it's stated in that page, and I can tell you why, if you'd like.

Q. Well, it is stated by the physician at

that time, true?

A. This is true.

Q. And, apparently, prior to the use of the creams, the patient could not have her husband enter her, correct?

A. It would appear that way.

Q. And Dr. Peacock noted that the vaginal tissue was improving once the patient had been on the cream for about a month, true?

A. Well, I think her records conflict with that finding, quite frankly.

Q. What conflicts with her records?

A. Well, her initial assessment on April 19th, there's no documentation whatsoever of any vulvar atrophy, so I don't understand her basis for saying vulvovaginal atrophy is improving when it wasn't even there in April.

Q. So why would she give her a prescription of Estrace and Vagifem?

A. I think it's not appropriate to do so for someone who has dyspareunia and who is not producing estrogen. I do that all the time, quite frankly. I just don't understand why she would make a comment to the effect of vulvovaginal atrophy is

improving where a month ago, based on her documentation, there was no vulvovaginal atrophy. That's my concern.

Q. But, in any event, her May 2012 report would indicate that her vaginal tissue atrophy was improving with the use of the estrogen creams and her dyspareunia improved as well, correct?

A. She made that comment, yeah.

Q. Had this patient had problems with dyspareunia in the past before she ever had a TVT-O?

A. She did.

Q. And what was that related to?

A. By her report and based on my discussions with her at the time of my IME, it was based on an episiotomy scar.

Q. And the episiotomy scar had to be revised?

A. The scar tissue was removed in 2003, in fact.

Q. Did she have a scar from the revision itself?

A. Based on my review of the medical records, it appears she doesn't have much scar tissue related to that.

Q. And you excluded pelvic floor dysfunction, true?
A. Yes, sir.
Q. Did any of the other physicians note pelvic floor dysfunction?
A. Yes.
Q. Who did?
A. Dr. Marinis entertained that diagnosis during his evaluation.
Q. And did he find it?
A. Well, he specifically, and I quote, entertained the diagnosis of pudendal neuropathy caused indirectly by the TVT-O mesh, and based on that, entertained that diagnosis and actually attempted treatment of such with medication.
Q. And your examination ruled that out as well, correct?
A. Yes, it did.
Q. Okay. So of the things you mentioned, vestibulitis now appears in the medical records, which you had overlooked earlier, correct?
A. I didn't see that.
Q. Okay. And the pain in the area of the colporrhaphy, that was in the medical records from

Dr. Chad Hill, correct?

A. That's correct.

Q. And does Dr. Peacock also address pain in the posterior of the vagina? She intends to do some type of physical therapy, correct?

A. It's suggested -- well, there were a couple of issues in the posterior wall that she discusses, one being the rectocele and the other being pain in the upper posterior area of the vaginal space.

Q. Neither one of those things would be related to mesh, true?

A. This is true.

Q. And like Dr. Miklos, Dr. Peacock also did not suggest that mesh was causing any of this patient's problems, correct?

A. There's no mention either of that in her notes.

Q. So we have two urogynecologists looking at this patient a few short months after the surgery by Dr. Marinis, correct?

A. Several months after she saw Dr. Miklos, and soon thereafter she saw Dr. Peacock.

Q. Neither one of these physicians mentioned the -- do you have your examination notes I

think we marked as an exhibit?

A. Yes, sir.

Q. Neither one of the physicians who saw this patient shortly after Marinis' deposition -- or surgery, I'm sorry -- indicated that this -- that they felt tenderness along the left vaginal sulcus where a palpable scar is appreciated, true?

A. I don't see that present in their records.

Q. And both conducted pelvic examinations on this patient, true?

A. They did.

Q. Then we go to Opinion Number -- one of the reasons for stating -- let me before we get to Opinion 5, one of the other reasons you stated that you felt there was a contraction is because she slowly had this inability to void, this slower urine flow and that this came on gradually after the TVT procedure, true?

A. It can occur gradually, this is true.

Q. Isn't one of the basis for your opinion that there was a contraction of the mesh is that the -- that there was this gradual development of slower flow and inability of her to empty her bladder?

A. Well, I think the healing process after

these procedures is such that although the development over a long period of time might seemingly be gradual, in a lot of instances, patients immediately following surgery can actually have voiding dysfunction primarily related to inflammation and swelling at the immediate time of surgery.

Q. It can also be related by over tensioning of the device, correct?

A. That can sometimes occur.

Q. Can you over tension one side but not the other?

A. It's somewhat difficult to do that, functionally and mechanically speaking.

Q. It doesn't really make sense, does it?

A. The point you just made you mean?

Q. It doesn't really make sense that you could have more tension on one side than the other in a TVT-O device?

A. Unless there's difficulty removing the sleeves around the mesh, it's very hard to imagine that happening.

Q. And there was -- have you ever been able to pull on a TVT-O while it's still implanted without opening up the patient?

A. I'm not sure if I understand that question.

Q. Well, you know, Dr. Marinis indicated he pulled on the TVT, and, in fact, the patient mentioned that as well, true?

A. I guess I'm trying to understand the context in which you're referring to that. You're talking outside of the operating room?

Q. Yeah, examination.

A. Oh, yes, he did, when he examined her -- I'm not convinced he actually pulled it, but he palpated it was my interpretation of that exam.

Q. She, in fact, told the told Dr. Peacock that it was never tender on exam when the sling itself was palpated only when pulling on it?

A. I'm not sure what to make of that. I don't understand that.

Q. Well, Doctor --

A. I saw that in her notes.

Q. It would hurt her if you pulled on it, wouldn't it?

A. How do you pull on it?

Q. That's what Dr. Marinis said he did, true?

A. I think Dr. Peacock made reference to that.

Q. And didn't Dr. --

A. My interpretation of Dr. Marinis was that he palpated it, and, in fact, I believe my report speaks to that. Yes.

Q. Let me ask you about this pelvic pain on the left vaginal sulcus. That's not posterior pain, true?

A. No, sir.

Q. I guess that would be --

A. It's fascial sulcus is not posterior, that's correct.

Q. Thank you for helping me out there.

The area that you identified pain was different than what Dr. Chad Hill identified, true?

A. No, not true.

Q. Okay. Chad Hill identified pain in the -- where the colporrhaphy was done in his examination, true?

A. Well, on September 29th, 2011 he states otherwise.

Q. But he says that's what the patient says, but, actually, on the examination three weeks

before that, he actually checked her, true?

A. He did examine her on July 11, 2011.

Q. And at that time he actually palpated the area where the colporrhaphy was done?

A. And, as I recall, he documented that it was a well healed colporrhaphy incision.

Q. And did he also testify that that was the area where she was feeling pain, where the colporrhaphy was done?

A. As I recall, yes.

Q. Okay. So that would be a different area than where you palpated and found tenderness, correct?

A. That's correct.

Q. And that's a different area, the area that you found pain was different than the area Dr. Peacock identified, true?

A. Well, it's unclear to me where Dr. Peacock felt pain, quite frankly, because her notes are conflicting.

Q. Well, certainly, the area that you felt pain would not lead one to a diagnosis of vestibulitis or the need for a vestibulectomy, correct?

A. This is true.

Q. And, likewise, the area you felt pain

would not lead one to the diagnosis or the need for a perineoplasty, correct?

A. To some extent, true.

Q. So both Dr. Miklos and Dr. Peacock were apparently identifying pain at a different spot than you were, correct?

A. Not necessarily.

Q. They certainly reached different diagnosis than you did, correct?

A. Well, they certainly reached different treatment plans, the both of them as well. I mean, one wants to do a perineoplasty, the other wants to do a vestibulectomy. One says there is no vulvovaginal atrophy, then she says the vulvovaginal atrophy is improving. So it's a little over the map, quite frankly.

Q. Would you agree with me that both the diagnosis and treatment plans of Dr. Miklos and Dr. Peacock are different than the diagnosis that you made?

A. I would conclude that all three are different.

Q. Okay. In Opinion Number 6 you say that she still has mesh in her body so she will continue to

experience dyspareunia?

A. That's correct.

Q. Where does she still have mesh?

A. When transobturator slings are implanted, there is a component of them that sits much like a hammock underneath the mid urethra and the vaginal space; however, there's also a component that exits the vaginal wall and extends through the obturator foramen and then comes out the groin crease bilaterally. When Dr. Marinis did his removal of the sling, he obviously left pieces in the left and right side in this patient.

Q. At the obturator?

A. I would argue near the obturator, and part of the reason I state that is because in a lot of instances when you examine these patients and you encounter an area of scar tissue, we call it induration sometimes, where the tissue is thickened, it's somewhat difficult to know if, in fact, that's purely fibrosis and scar tissue or whether or not there's any residual mesh there.

Q. There is no scar tissue -- there is no mesh in the area that you identified, currently there's no mesh in the area where you identified tenderness on

the vaginal sulcus, correct?

A. Well, that's not true exactly.

Q. Do you contend there is?

A. I would contend there most likely is, yes.

Q. Okay. And you say her dyspareunia would be ameliorated with further sling removal, correct?

A. Possibly, yes.

Q. And we can agree that that was not recommended by Dr. Miklos or Dr. Peacock, true?

A. True.

Q. How much were you paid to do the IME in this case?

A. I wasn't paid to do the IME, my group was paid.

Q. Okay. How much were they paid?

A. I believe $350 or thereabouts.

Q. How many did you do that day, IMEs?

A. On that day, give you an exact answer, so give me one moment, please.

Yes, I did three that day.

Q. And that's Ms. Bailey, Ms. Martin and who else?

A. No, I did Mrs. Martin, Mrs. Manor and a

patient by the name of Macina.

Q. Did you do Bailey that day as well?

A. I did not.

Q. What is a relaxing perineoplasty?

A. Well, the easiest place to improve vaginal introital caliber is via a perineoplasty, and what that entails doing is removing, in this instance, either fibrotic -- possibly fibrotic and/or scar tissue in the hopes of expanding the vaginal opening, hence the concept of relaxing.

Q. Is there fibrotic tissue where the episiotomy was done and the episiotomy revision?

A. There's no documentation of that following her original episiotomy revision. That being said, she's had a posterior colporrhaphy since that time, so it's likely that there is.

Q. Okay. And that would have been the area that Dr. Miklos was operating in, true, wanted to operate in, correct?

A. One of the areas, yes.

Q. The other was to do the Burch procedure for the incontinence on his two recommendations, correct?

A. Partially correct, yes.

Q. And the area where he would do the perineoplasty was probably where the colporrhaphy scar is; is that what you're saying?

A. Not necessarily, no.

Q. Do you know where it is?

A. Well, the perineum is the very most distal element of the posterior wall, so posterior colporrhaphy extends from the perineum back towards the apex, if you will, of the vagina, the back part of the vagina.

Q. Right.

A. So it doesn't incorporate the entire area.

Q. Oh, so you're saying partially it includes that area?

A. It may. It depends on where the rectocele was located. If the rectocele was a more apical rectocele, you might not even get in touch with the perineum.

And, as I recall, based on Dr. Hill's operative note, I don't believe he does a perineoplasty, although I may be incorrect on that. I don't recall that being part of his surgery, although it typically is. At least in my practice it is.

Q. So that would be the area of scar revision, though, is that what we're talking about, when Dr. Miklos suggests the perineoplasty?

A. In part, yes.

Q. It's where the colporrhaphy scar is and the pre-existing perineoplasty was probably done, correct?

A. I can't draw that conclusion, it might be.

Q. Okay. I mean, that's the most logical thing, correct?

A. It might have nothing do with Dr. Hill's posterior repair, quite frankly.

Q. It doesn't have anything to do with the mesh either, true?

A. Once again, Dr. Miklos stated -- counseled the patient towards vaginal and vulvar scar revision with perineoplasty and laparoscopic Burch. So, certainly, the perineoplasty would have nothing to do with the mesh.

Q. Okay. Tell me, what other procedures do you perform for stress urinary incontinence, other than the mesh procedures?

A. I perform suburethral collagen or

similar like injections. I also perform autologous fascial slings. I have had experience implanting biological graph materials for stress urinary incontinence.

Q. Those aren't available anymore, though, as I understand it?

A. That's correct.

Q. And the autologous sling procedure that you do --

A. Yes, sir.

Q. -- do you counsel the patients that there is a risk of dyspareunia or pain with intercourse as a potential complication of that procedure?

A. I do.

Q. And is part of the reason for that that you actually have to, I guess, make an incision through the vagina?

A. Yes, sir.

Q. And any time you do that, there's the potential for dyspareunia or pain with intercourse, correct?

A. That's true.

Q. And I guess even Burch procedures, they could lead to dyspareunia and pelvic pain as well,

correct?

A. That's correct.

Q. Any time you're operating in the vaginal vault, you would have to counsel the patient about the potential for dyspareunia or pain with intercourse, true?

A. This is true.

Q. And even if Ms. Martin had come to you for an autologous sling procedure, you would have counseled her that there was a risk of dyspareunia, true?

A. I would have counseled her towards the differences between mesh and the autologous fascial sling with regards to every complication, indeed.

Q. You would have laid out the options for the two procedures, true?

A. That's correct.

Q. And if she selected the autologous procedure, you would have counseled her that there is a risk of dyspareunia with that procedure, true?

A. And less so with mesh, but, yes, true.

Q. So even if Ms. Martin had had an autologous sling procedure, there's the potential for pain with sex, true?

MR. THOMPSON: Object to form.

THE WITNESS: That's a fair comment.

BY MR. GRIFFIN:

Q. And I guess scarring is also a risk with the sling -- with the autologous sling procedure where you've made your incision, true?

A. Correct.

Q. Is it fair to say that the complication Ms. Martin has regarding painful intercourse is a potential complication of the nonmesh surgeries that are used to treat stress urinary incontinence as well?

A. I don't know if I can answer that question, as she has not had any nonmesh based anti-incontinence procedure.

Q. I guess what I'm saying is every one of the -- other than collagen, but any of the surgical procedures that the patient might have for stress urinary incontinence had the potential complication of painful intercourse, correct?

A. This is true.

Q. So even if she had a nonmesh procedure, she faced that potential complication, that being painful intercourse, correct?

A. This is correct.

Q. In fact, the Burch procedure suggested by Dr. Miklos carried the risk of dyspareunia as well and pelvic pain, correct?

A. I believe he actually wrote the number in his consent.

Q. The percentages?

A. It was very low, less than 1%, I think he said.

Q. That was -- that clearly looked like it was based on his experience?

A. That's correct.

Q. Is that how you looked at it?

A. That's how I looked at it, and that's roughly an appropriate quote for the standard urologist, urogynecological surgeon.

Q. There's no way that you could say more probably than not that any removal of additional mesh would change the picture of her dyspareunia, correct?

MR. THOMPSON: Object to the form.

THE WITNESS: It's possible it might help.

BY MR. GRIFFIN:

Q. But there's no way for you to say more probably than not that it would, true?

MR. THOMPSON: Object to the form.
THE WITNESS: It's hard for me to make that -- to formulate that opinion.
BY MR. GRIFFIN:
Q. It's impossible at this point, true?
MR. THOMPSON: Object to the form.
THE WITNESS: I think I said possibly before, so I guess I don't want to conflict what I just said before.
BY MR. GRIFFIN:
Q. Okay. There's no way for you to say more probably than not that removal of additional mesh would improve Ms. Martin's dyspareunia, correct?
MR. THOMPSON: Object to the form, asked and answered.
THE WITNESS: The only way to really answer that question would be to remove the additional mesh and formulate that decision or opinion.
BY MR. GRIFFIN:
Q. So the answer is no?
MR. THOMPSON: Object to the form.
THE WITNESS: I can't answer that question as it's asked.

BY MR. GRIFFIN:

Q. Okay. Is there any way you can say more probably than not that additional mesh removal would improve Ms. Martin's dyspareunia?

A. It might help.

Q. Can you say more probably than not that it would?

A. As my report states, they might be helped.

Q. And my question is can you say more probably than not that it would help?

MR. THOMPSON: Object to the form.

THE WITNESS: You know the problem with answering that question is that I guess, first off, each patient is unique, so it's kind of like asking if someone is pregnant, you know, either you are or you're not, right.

For me to answer that question can only be determined by doing it and seeing it, and the reason I answer it like that is because with each additional surgery she has, there will be more fibrosis and more scarring.

For example, with Dr. Marinis' surgery where he targeted her dyspareunia as being

anterior vaginal related to the sling and then over the next six months she has differing opinions and then sees me three years later and, lo and behold, at least on my examination, her pain is more anterior vaginal wall located. It's hard to say if additional mesh removal may help because in so doing, one might be removing the offending agent but in the process creating more scar tissue, and that's why I'm not trying to be difficult, but that's why it's hard for me to answer your question.

BY MR. GRIFFIN:

Q. We do know that removal of the TVT mesh did not cure her dyspareunia, did it?

A. Well, we're not clear on that.

Q. The procedure that Dr. Marinis did did not cure her dyspareunia, correct?

A. Not ultimately, it did not.

Q. And I guess there's no way for you to say whether the vestibulectomy or the perineoplasty recommended by Dr. Peacock and Dr. Miklos would or would not help her dyspareunia, true?

MR. THOMPSON: Object to the form.

THE WITNESS: I would agree with that

question.

BY MR. GRIFFIN:

Q. It may or may not -- those procedures may or may not help her dyspareunia would be your response, true?

A. They might help it somewhat.

Q. So in addition to what you identified as a potential reason for her dyspareunia, you would agree with me that other potential causes exist, including vestibulitis, the potential need for perineoplasty and vaginal atrophy, true?

MR. THOMPSON: Object to the form.

THE WITNESS: I would not agree with that wholeheartedly, no.

BY MR. GRIFFIN:

Q. Halfheartedly?

A. About one-third-heartedly.

Q. Okay.

A. No, the reason I say that, not to be cheeky, is because I have no evidence based on my clinical exam and history taking that vestibulitis is part of this problem. Inasmuch as vulvovaginal atrophy might be part of this problem, her dyspareunia seems to both precede that diagnosis and seems to be persisting

despite the adequate treatment of that diagnosis.

Q. Okay. So the vaginal atrophy, at least according to Dr. Peacock's records, might be a partial cause, you would give it that, correct, for dyspareunia?

A. Inasmuch as in 2016 she hasn't had sex in three years, despite that therapy, I'm hard pressed to imagine it being a real significant issue for her.

Q. Did you check to see -- one of the things you pointed out was that due to the contractions, the trabeculations occurred in the bladder itself, true?

A. That was pointed out by Dr. Marinis.

Q. And did you do a cystoscopy to determine whether they still existed or not?

A. I did not.

Q. They should still exist, though, if you do a cystoscopy, correct?

A. To some degree you should see some findings.

Q. Did you look for subsequent cystoscopies to see if, in fact, there was evidence of that?

A. I think she may have had a cystoscopy by Dr. Peacock, but I don't recall that.

Q. And Dr. Peacock, in fact, found no evidence of trabeculations based on her examination, did she?

A. Probably, if it would be okay, I'd like to see those records, just to refresh my memory.

There's no comment made towards the presence of trabeculations.

Q. So they do not appear in 2012 after Dr. Marinis saw them apparently in 2011?

MR. THOMPSON: Object to the form.

THE WITNESS: Interestingly enough, there's no comment made to that effect in Dr. Peacock's notes.

MR. GRIFFIN: I will reserve any remaining time.

BY MR. THOMPSON:

Q. Doctor, let me ask you just a couple of questions. You've had an opportunity to look at -- you've been confronted with and had an opportunity to look at Dr. Peacock's notes?

A. Yes, sir.

Q. Also, you've had a chance to review Dr. Miklos and you've been reminded of Dr. Hill's deposition.

Do any of the facts that are contained within those records or reports alter your opinions that you've rendered previously in this case?

A. They do not.

Q. Doctor, your -- to the extent that you are examining Ms. Martin in 2016 personally, do you give the IME more weight or do you -- strike that.

Do you view the medical records from the perspective of having given a IME and given a personal physical examination of Ms. Martin?

MR. GRIFFIN: Object to form.

THE WITNESS: I do.

BY MR. THOMPSON:

Q. To the extent that various doctors have identified various locations of pain within the vagina of Ms. Martin, we can all be -- we can all agree that she only has one vagina, right?

A. I would hope so, yes.

Q. And would you agree that the pain that she evidenced to you in 2016 was related to the site of the mesh?

MR. GRIFFIN: Object to form of the question.

THE WITNESS: Yes.

BY MR. THOMPSON:

Q. Doctor, I notice in your report that you give the opinion -- that you sign the opinion -- I need to ask you one more question, are the opinions that you express within this report rendered within your expertise to a reasonable degree of medical certainty?

A. Yes.

MR. THOMPSON: Mr. Griffin, that's all I'm going to ask.

BY MR. GRIFFIN:

Q. You indicated that none of your opinions changed despite the fact that you had reviewed now or been back through the records of Dr. Peacock, Dr. Miklos and Dr. Hill's testimony, correct?

A. Yes, sir.

Q. Is one of those opinions excluding periurethral banding?

A. It is, yes.

Q. What is periurethral banding?

A. Periurethral banding describes a condition where usually in the presence of mesh, there can be a palpable band of tissue that neither expands and has essentially a feeling of a palpable scar, that can be a source of dyspareunia. It's sometimes

described banding as well as just the presence of scar tissue per se, but, classically, that's described as a palpable band that one feels, where there is a scar plate and mesh together.

Q. And you did not find that in this patient, true?

A. No, there was no -- her mesh had been removed, so I didn't formulate that finding.

Q. You were not able to palpate any mesh, true?

A. Not necessarily true.

Q. Did you feel any?

A. Well, as we discussed, that area in that left vaginal sulcus very well could have mesh behind it or underneath it, but there was such thick scar that I really can't make a definitive comment that there's mesh there.

Q. Did you find any erosion, exposure or anything of mesh during your examination?

A. I did not.

Q. You also state in here that you were able to exclude vestibulitis as a cause for Ms. Martin's vaginal pain and dyspareunia because there's no evidence in the medical records of the

presence of this condition.

Do you want to take that back now?

A. Well, I think if you look at my report, what you'll actually see is that Dr. Peacock's notes were not part of my review.

Q. Okay. So now that you've had a chance to review Dr. Peacock's records, do you want to take that back?

A. I would modify that sentence. I would still exclude it, but I would exclude it having respectfully reviewed and perhaps refuted Dr. Peacock's findings.

Q. You would exclude it based upon what you found in 2016, true?

A. Certainly, that's true, yes.

Q. But you would not necessarily exclude it that that may have been the cause of her dyspareunia in 2012 because you didn't have an opportunity to examine her at that time; would that be fair?

A. I would probably agree on the basis saying one of the causes of her dyspareunia. I think it's fair to discuss that as part of the differential.

Q. So one of the causes of her dyspareunia in 2012 was the vestibulitis, true?

A. Possibly.
Q. Okay. And one of the causes of her dyspareunia in 2012 may have been her need for perineoplasty, true?
A. That's what Dr. Miklos had opined.
Q. True?
A. I think that's part of it, possibly.
Q. Those diagnosis were made by urogynecologists?
A. Yes.
Q. Just so I know, are you -- you're a gynecologist, true?
A. No, I'm a urologist.
Q. You're a urologist?
A. Yes, sir.
Q. Are there urogynecologists in your group?
A. Yes. Well, there's one urogynecologist in my group, yes.
Q. What training do urogynecologists have that urologists don't or vice versa?
A. The difference between the two specialities is that a urogynecologist completes a formal residency in obstetrics and gynecology and then

does anywhere from a two to three-year fellowship in urogynecology. Whereas urologists typically complete a five to six-year residency involving both general surgery and urology and then embark on what's called a female urology fellowship, which can be anywhere from one to three years, depending upon academic, research, clinical work, et cetera.

MR. GRIFFIN: I don't have any other questions.

MR. THOMPSON: Thank you. I don't have any redirect.

(Witness excused.)

(Deposition concluded at 10:48 a.m.)

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C E R T I F I C A T I O N

I, MARGARET M. REIHL, a Registered Professional Reporter, Certified Realtime Reporter, Certified Shorthand Reporter, Certified LiveNote Reporter and Notary Public, do hereby certify that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place, and on the date hereinbefore set forth.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.

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Margaret M. Reihl, RPR, CRR, CLR
CSR #XI01497 Notary Public

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ACKNOWLEDGMENT OF DEPONENT

I, KONSTANTIN WALMSLEY, M.D., do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

KONSTANTIN WALMSLEY, M.D. DATE

Subscribed and sworn to before me this

_____ day of _____, 2016.

My commission expires:_____

_____

Notary Public